Programme Update on Community Action for Health
Madhya Pradesh

BACKGROUND

Pre-pilot Phase

During 1990s, the state government constituted 7 different standing committees of Gram Panchayat for education, health, and other social issues. Though the initiative was externally funded, it was part of state's commitment for decentralization. Later, the programme was discontinued but, some committees were remained. In 2001, the state government started '**Swasthya Jeevan Seva Guarantee Yojana**' under Rajiv Gandhi Mission including components such as iodine deficiency, sanitation and potable drinking water. It also made provisions for community volunteers- **Jan Swasthya Rakshak**, and provided them a six month training.

Pilot Phase (2007-2009)

Madhya Pradesh was one of the 9 states in which the pilot phase of Community Based Monitoring (CBM) programme was implemented from April 2007 to July 2009. It covered 225 villages (41 PHCs) of 15 blocks across 5 districts: Guna, Chindwara, Sidhi, Badwani and Bhind. An external group of experts was constituted to review this phase. Key findings were:

S.N.	Activities	Number
1	VHSNCs formed and oriented	225
2	PHC level planning and monitoring committees formed and oriented	41
3	Block level Planning and Monitoring Committees formed and oriented	14
4	District level Planning and Monitoring Committees formed and oriented	4/3
5	Village Health profiles and VHSC Report Card prepared	225
6	PHC/block report card prepared	41/14
7	Jan Sunwais organised at PHC/block level	31/7

(i) Involvement of Civil Society Organisations (CSOs): Madhya Pradesh Vigyan Sabha (MPVS) and SATHI CEHAT were the state nodal agencies to implement the programme in the state. A State Mentoring Group (SMG) was constituted with 10 members, out of whom six were from the civil society. This group was headed by Principal (Secretary Health &FW). Only one meeting of this group was held during this period and its role was not clearly spelt out. In addition, a state level resource group with 14 members was also set up. Though the district nodal NGOs were selected at the district level, no official order was issued. District Mentoring Groups (DMGs) were constituted and its first meeting was held. Subsequently, it was inactive due to inability for devoting spare time, no clarity on roles and responsibilities, and lack of accountability and clarity on future roles.

(ii) Planning and Monitoring Committees (PMCs): Planning and Monitoring Committees were constituted at the district, block and PHC levels. However, these committees were not functional at the PHC and block level and members were not aware of their roles and responsibilities. Government was reluctant to involve PRI members; and the health officials were of the opinion that the community monitoring should be made as part of regular HMIS.

(iii) Village Health, Sanitation and Nutrition Committees (VHSNCs): In the beginning, there was not much aware about VHSNC, which was existed only on papers. Except ANMs, AWWs and Sarpanchs nobody had ever heard about these committees. NGOs involved in the pilot phase were reconstituted by this 10-member committee which were later approved by Gram Sabhas. Reconstitution of VHSNCs was a long drawn process and it took about 5 meetings to finally constitute them. Funds were not sanctioned to these committees.

Key processes undertaken during the pilot were: (i) orientation of VHSNC, Planning and Monitoring Committee members and health providers on community based monitoring; (ii) organise community enquiry process through VHSNCs; (iii) preparation of facility report cards; (iv) organisation of media workshops; and (v) organisation of Jan Samwads at the PHC and block levels. Block facilitators, working with implementing NGOs, conducted community enquiry and facilitated preparation of report cards. The tools and the scoring were not able to capture community perceptions as intended and equity index was generally left blank. However, it was helped to raise awareness among the community on health services.

Post Pilot phase

Gram Sabha Swasth Gram Samiti (GSSGS)

In 2008-09, VHSC and Village Water and Sanitation Committee were merged. Later, the departments of Panchayat and Rural Development, Health and Family Welfare, Women and Child Development, and School Education of the Government of Madhya Pradesh decided to merge all the existing committees into a single entity titled **Gram Sabha Swasth Gram Samiti**.

The 'Swasth Gram Samiti' is an ad-hoc committee of the Gram Sabha constituted under the Madhya Pradesh Panchayati Raj Act. This committee has 20 members; at least 50% of whom were women. The members were nominated by the Gram Sabha with representation from weaker sections. All elected women Panchayat members, ANMs, AWWs, ASHAs, hand pump mechanic, chairpersons of Matra Sahyogini Samiti and self-help groups providing mid-day meal were ex-officio members of GSSGS.

The GSSGS was chaired by a woman representative and ASHA was the secretary. **The health fund account was operated jointly by the Chairperson and ASHA** and audited regularly. It was mandatory to conduct meeting of the GSSGS once in a month. The GSSGS had performed the roles and functions of the VHSC as originally planned in the NRHM.

GSSGS were constituted in 47,959 villages out of 53,035 in the state. In 2013-14, untied fund was sanctioned to the villages those having a population of more than 200. 30,927 GSSGS utilised this untied fund till January 15, 2014.

Activities undertaken during 2010- 2012

The programme was implemented in 10 districts with a budget of Rs 20 lakhs. Rs 1.71 crores were allocated for high focus districts and Rs 2.023 crores were allocated for state level coordination. It was decided to include five new districts in this FY: four districts from the pilot: Chindwara, Sidhi, Badwani and Bhind; and Guna (replaced with Betul).

Activities undertaken during 2012-14

ASHA Resource Centre and Mentoring Group for Community Monitoring were merged and the Mentoring Group for Community Action (MGCA) was constituted with focus on ASHA programmes, VHSC and community monitoring but, later its scope was widened with maternal health, child health, Immunization, family planning and other programmes.

Mentoring Group for Community Action (MGCA) at state level

ASHA Resource Group in Madhya Pradesh was converted into Mentoring Group for Community Action (MGCA). It has 35 members with MD, NRHM as chairperson. Other members include: Director-RCH/NRHM, Joint Director-NRHM, deputy directors, donors, partners, civil society organisations, members of AGCA and the members of national ARC. 2-3 districts have been allocated to each MGCA member to undertake visits and monitor the programme. Brief roles of MGCA members are given as follows:

1. Activate community processes
2. Provide supportive supervision of:
    a. ASHA - incentives, grievances and functioning.
    b. Swasth Gram Samiti - training, meetings, untied fund utilization.
    c. Immunization - community participation, organisation of VHND
    d. Family planning - social marketing of condoms, OCPs, ensure quality of services
    e. MCH including nutrition - JSY, JSSK implementation, follow up of children discharged from Nutrition Rehabilitation Centre.

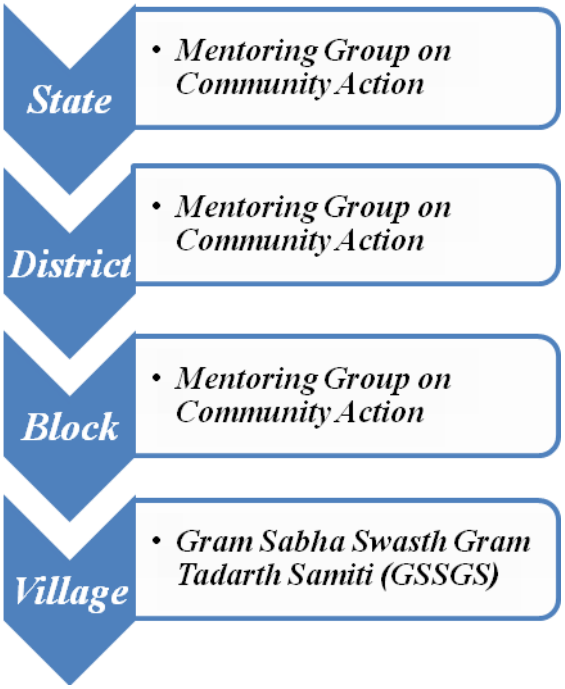
f. National Programmes - involvement of ASHA in DOT, Malaria, Leprosy, HIV testing.

3. Documentation of experiences from the field, replicating innovations to the state and sharing of best practice
4. Performance review of programmatic progress
5. Strengthening of ASHA schemes in the state and establishing grievance redressal mechanism.

Mentoring Group for Community Action (MGCA) at district and block level

MGCA was also constituted at the district and block levels. Both district and block level MGCA have 15-20 members including 3-4 representatives from NGOs, 2 ASHAs, 2 VHSNC representatives, and representatives from Panchayat, Education and WCD departments.

Figure 1- Structures of CAH



The MGCA members provide guidance and supportive supervision and monitoring of ASHA programme, VHSC and community monitoring processes along with organisation of training. A District MGCA member has the responsibility of 2-3 blocks whereas a Block MGCA member has the responsibility of couple of Panchayats only. MGCA members build the capacity of MGCA members at the lower levels. The mandates of district and block level MGCA members are:

1. Plan for strengthening functioning of communitization processes including ASHA, GSSGS and community monitoring
2. Increase community participation for developing integrated district health plan
3. Visit blocks and Panchayats for monitoring, provide support and guidance
4. Preparation of evaluation report of ASHA support system
5. Documentation of process outcomes and related case studies.

1n 2014, **'Gram Arogya Kendras (GAKs)'** or 'Village Health Centres' (VHCs) had been launched under the 'Sampoorna **Swasthya Sabke Liye'** programme by the State government. Under GAK, a centre for information and guidance was set up in every village (preferably in Anganwadi /ICDS Centre). Community Action was planned to be linked with these VHCs.

Activities undertaken during 2014-16

The community action for health process has been re-initiated in five 'intensive community monitoring' districts: Barwani, Betul, Bhind, Chhindwara and Sidhi. Training of Trainers (ToTs) for district community mobilisers, district project managers and members of Mentoring Group for Community Action (MGCA) were organised. To gear up the people at the key positions, chief medical and health officers (CMHOs) were oriented, which was resulted a push in approach from the administrative side.

ToTs in progress for DCMs, DPMs and Regional Directors

Sharing of reports with community

Jan Samwads in progress at the block level

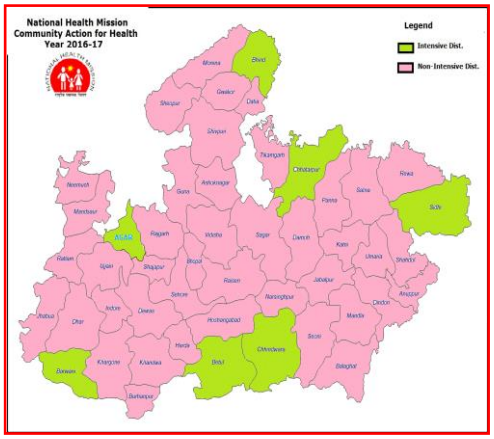
जनसंवाद गोहद में आयोजित जनसंवाद के दौरान सीएमएचओ से लोगों ने की शिकायत

गांव में नहीं लगते स्वास्थ्य शिविर, हर घर में लोग बीमार

शिकायत मिलने पर होगी कार्रवाई

Media Coverage on Jan Samwads

Community enquiry processes in the five intensive community monitoring districts were completed. Subsequently, 15 Jan Samwads were organised in these intensive districts in September 2016. AGCA co- facilitated Jan Samwads in three districts. Later on, two more districts: Agar and Chhattarpur were added in the intensive districts.



Intervention	Districts	Blocks	PHCs	VHSNCs
Intensive	5+2=7	21	63	315
Non-Intensive	44	292	-	49,252
Total	51	313	63	49,567

Activities Undertaken during 2017-19

A two pronged strategy was used to implement the CAH processes in the state: (a) implementation of intensive processes in 7 districts: Barwani, Bhind, Betul, Chhindwara, Sidhi, Agar; and Chhattarpur (b) implementation of non-intensive processes across all the remaining 44 districts, focusing on the use of the public service monitoring tools by VHSNC members.

All the CMHOs and regional directors of 44 remaining districts were oriented on CAH process. 91 people from all across the state were oriented. A detailed implementation plan for rolling out the processes in the field was also developed. Subsequently, a comprehensive report was developed on the issues and gaps identified and the action taken from the Jan Samwads organised in five districts, followed by institutionalisation of the community monitoring process with District Community Mobilisers (DCMs), who are currently uploading community monitoring data as part of their Management Information System (MIS).

Activities undertaken during 2019-20

In the current year, 10 districts were taken up as intensive districts. Khandwa, Hoshangabad and Videsha were added in the intensive districts. As discussed at the MGCA meeting, a refresher training on CAH tool was organised for state and district level MGCA members along with district community support structures (DCM, DPM, BCMs and M&E level officers). AGCA Secretariat facilitated the training in two districts: Hoshangabad and Videsha and the rest were facilitated by the State MGCA members.